LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

301 State House
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FISCAL IMPACT STATEMENT

LS 6266 **DATE PREPARED:** Feb 15, 2001
BILL NUMBER: HB 1879 **BILL AMENDED:** Feb 13, 2001

SUBJECT: Medicaid Drug Formularies.

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FUNDS AFFECTED: X **GENERAL** **IMPACT:** State
DEDICATED
X **FEDERAL**

Summary of Legislation: (Amended) This bill defines "therapeutic classification". The bill provides that the Medicaid program or a Medicaid managed care organization (MCO) may require prior authorization of a drug only to restrict access to single source drugs that are subject to clinical abuse or misuse. The bill also provides criteria for the Drug Utilization Review Board to consider in determining whether to approve a Medicaid managed care organization's proposal to remove or restrict a single source drug. It also provides that a Medicaid MCO may remove or restrict a single source drug only under certain conditions. (The introduced version of this bill was prepared by the Interim Study Committee on Medicaid Oversight.)

Effective Date: July 1, 2001.

Explanation of State Expenditures: (Revised) This bill is expected to increase state expenditures in the Medicaid program. The additional costs to the state are estimated to be greater than $1.6 M per year, but less than $3.5 M per year, based on current enrollment. To the extent that future enrollment within the Risk-Based Managed Care (RBMC) program increases above current levels, the impact would increase proportionately. However, the entire impact is also not expected to occur immediately, but may build up over time as costs are factored into the negotiated capitation rates of the managed care organizations. (Total expenditures are estimated to potentially increase by $4.1 M to $9.1 M with $2.5 M to $5.6 M in federal reimbursement, based on current RBMC program enrollment levels.)

Background: This bill can impact Medicaid expenditures for pharmaceuticals by: (1) restricting the ability of the Medicaid program and managed care organizations in the Medicaid RBMC program to utilize prior authorization (except for single source drugs subject to clinical abuse or misuse) and (2) through the statutory requirement that Medicaid MCOs must provide at least two therapeutically equivalent drugs within each therapeutic classification on their formularies (and the effect the bill's definition of "therapeutic classification" may have on that requirement). Both of these provisions restrict cost-containment efforts in the Medicaid program and by Medicaid MCOs. Restriction in the ability to use these tools can ultimately

result in higher pharmaceutical expenditures, either directly to the Medicaid program or through future managed care capitation rates negotiated with MCOs.

The Office of Medicaid Policy and Planning (OMPP) estimated the per member per month (pmpm) cost for pharmaceuticals paid through the state's Primary Care Case Management program (fee-for-service) as $17.56. The pmpm for pharmaceuticals through one managed care organization in the Risk-Based Managed Care (RBMC) program is $10.11. The restriction in the use of cost-containment tools could result in higher pharmaceutical expenditures faced by this one MCO and, potentially, could have some effect on all of the MCOs. The maximum impact could range up to the average pharmaceutical price level currently faced in the fee-for-service program.

The range in estimates provided above is determined by applying the difference in pharmaceutical costs of $7.45 per person per month in the one MCO for which this bill will have the greatest impact and applying that differential to the number of enrollees in that MCO. (This results in the lower estimated impact of $1.6 M in state costs.) However, the other MCOs are likely to be impacted by the bill as well, albeit to a probably lesser and currently unknown extent. Applying the $7.45 pmpm cost differential to all 102,000 recipients in the RBMC program would represent the ultimate exposure to the state of $3.5 M under the current RBMC program enrollment. Due to the data used in determining these estimates, neither end of the range is likely to occur: the most likely impact lies somewhere within the range.

These estimates are based on the current enrollment within the RBMC program. To the extent that the managed care program enrollment increases, the impact of the bill would increase proportionately.

(Not estimated in the impact provided above is a potential impact on administrative costs that may be faced by the state. The extent of this impact has not been established at this time.)

The expenditures of the Medicaid program are shared. The federal government reimburses the state for about 62% of the expenditures, and the state share is 38%.

Explanation of State Revenues: See Explanation of State Expenditures, above, regarding federal financial participation in the Medicaid program.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: Office of Medicaid Policy and Planning.

Local Agencies Affected:

Information Sources: Kathy Gifford, OMPP, (317) 233-4455.